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	17E242	A. BUILDING _____ B. WING _____	12/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL ONAGA LTCU	206 GRAND AVE ST MARYS, KS 66536

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: The facility reported a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a comfortable and clean environment for residents on 1 of 2 hallways. Findings included: - Environmental tour dated 12/22/14 at 9:00 A.M. to 9:30 A.M. with maintenance/housekeeping staff X revealed the following: The South hallway revealed one resident's room had a broken window blind in the bathroom window. One resident's room had off color spackle on the bathroom wall and different wall paint. One resident room had large spackle patched along the wall at the resident's head of bed. Throughout the environmental tour on 12/22/14 maintenance/housekeeping staff X, acknowledged the above concerns. The policy and procedure dated 12/22/14 titled	F 253		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 253	Continued From page 1 Preventive Maintenance and Inspections revealed in order to provide a safe environment, a preventive maintenance program would be implemented to promote the maintenance of equipment and premises in a state of good repair and condition. The facility failed to maintain a clean and comfortable environment for the residents.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		

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material and false statement.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to comprehensively assess 1(#24) resident for hospices and 1(#32) resident for falls.

Findings included:

- The Significant Change in Status Minimum Data Set (MDS) dated 8/10/14 for resident #24 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 7 (severe cognitive impairment), and received hospice services.

The MDS lacked documentation the resident had a life expectancy of less than six months.

The signed telephone order dated 8/7/14 revealed orders for hospice services with a diagnosis of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), life expectancy of less than six months, provide comfort measures only, and no not resuscitate (DNR).

Observation on 12/22/14 at 8:30 A.M. the resident layed in bed.

On 12/23/14 at 9:52 A.M. administrative nursing staff E stated the MDS should have reflected the resident had less than six months or less of life expectancy.

The policy and procedure dated 11/2003 titled

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Long Term Care Resident Assessment and Care Planning Process revealed qualified staff would assess residents throughout the resident's stay with the facility to provide the appropriate care to meet the resident's needs.

The facility failed to provide a comprehensive assessment for this resident who received hospices services.

- The Quarterly Minimum Data Set (MDS) dated 10/8/14 for resident #32 revealed a Brief Interview for Mental Status (MDS) score of 5 (severe cognitive impairment).

The MDS lacked documentation the resident fell 8/8/14.

The Nurses Notes dated 8/8/14 at 12:00 P.M. revealed the resident's chair alarm sounded and nursing staff found the resident standing in front of her/his living room chair. The resident lost her/his balance and staff assisted the resident to the floor.

Observation 12/22/14 at 8:53 A.M. the resident sat in a recliner chair in the common living room with a chair alarm in place.

On 12/23/14 at 9:52 A.M. administrative nursing staff E stated the Quarterly MDS should have reflected the resident's 8/8/14 fall.

The policy and procedure dated 11/2003 titled Long Term Care Resident Assessment and Care Planning Process revealed qualified staff would assess residents throughout the resident's stay with the facility to provide the appropriate care to

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F 278	Continued From page 4 meet the resident's needs. The facility failed to provide a comprehensive assessment for this cognitively impaired resident with a history of falls.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. The sample size included 12 residents. Based on observation, record review and interview the facility failed to revise the care plan for 4 residents (#13, #22, #1 and #34).	F 280		

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-Findings included:

- The significant change Minimum Data Set (MDS) dated 7/18/14 for resident #33 revealed the resident had severe cognitive impairment and required limited to extensive assistance of two staff members for transfers and locomotion.

The quarterly MDS dated 12/17/14 revealed the resident had severe cognitive impairment and required total assistance of two staff members for transfers and locomotion. The resident did not walk at this time.

The care plan was revised on 12/22/14 revealed the resident had a shuffling gait and walked with two staff. The care plan also revealed the resident required a total mechanical lift for transfers.

Observation on 12/23/14 at 7:25 A.M. direct care staff O and direct care staff P transferred the resident using a total mechanical lift from his/her bed to wheelchair.

Interview on 12/22/14 at 3:07 P.M. direct care staff Q revealed the staff transferred the resident using a total mechanical lift, and he/she was not capable of walking.

On 12/22/14 at 3:17 P.M. licensed nursing staff H revealed the direct care staff transferred the resident using a total mechanical lift at all times, and no longer had the ability to walk. The administrative nursing staff was responsible for updating the care plans.

On 12/23/14 at 10:23 A.M. administrative nursing staff revealed the care plans would be

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individualized and accurate for each resident. The administrative nursing staff were in charge of updating the care plans as needed. He/she voiced that resident # 33 care plan should have been updated since he/she was not walking at that time.

The policy and procedure for revising the care plan dated 9/1/14 provided by the facility revealed the care plan would be updated with new or modified interventions.

The facility failed to update this cognitively impaired residents care plan to reflect the resident's physical capability including that he/she was not walking.

- The quarterly Minimum Data Set (MDS) dated 11/12/14 for resident # 1 revealed the resident had severe cognitive impairment and had upper and lower bilateral (both sides) impairment. The resident received restorative nursing and wore a splint.

The care plan revised on 11/13/14 revealed the resident received restorative nursing 5 to 7 times weekly and wore a hand and elbow splint daily that was removed at bedtime.

Review of the care plan progress notes revealed the resident did not want to continue restorative therapy as it was causing him/her to much pain.

Observation on 12/22/14 at 11:23 A.M. the resident sat in his/her wheelchair with no splint in place.

On 12/22/14 at 1:39 P.M. the resident sat in his/her wheelchair visiting with family not wearing

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his/her splint.

Interview on 12/22/14 at 2:23 P.M. direct care staff R stated he/she was in charge of restorative nursing and the resident was not currently on a restorative program which included his/her splint as it caused him/her pain.

On 12/23/14 at 9:04 A.M. licensed nursing staff J revealed the resident no longer wears the hand splint due to pain, and expected the care plan to reflect this.

On 12/23/14 at 10:23 A.M. administrative nursing staff D revealed the resident did not wear a splint at this time as reflected in the care plan progress note it was causing him/her too much pain. Administrative nursing staff revised care plans and expected the care plan to reflect the resident was not receiving restorative therapy or a splint.

The policy and procedure for revising the care plan dated 9/1/14 provided by the facility revealed the care plan would be updated with new or modified interventions.

The facility failed to update this cognitively impaired residents care plan to reflect the residents decision to discontinue his/her restorative program.

- The Significant change Minimum Data Set (MDS) dated 12/3/14 for resident #34 revealed the resident had severe cognitive impairment and he/she required extensive assistance from 2 staff members for transfers.

The Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 12/8/14 lacked how to

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identify how the resident was transferred.

The care plan revised on 12/15/14 revealed the resident was assisted by two staff members with the sit to stand lift for transfers and could walk, the care plan also identifies the resident was assisted by two staff members with the full mechanical lift for transfers.

Observation on 12/23/14 at 10:14 A.M. the resident was assisted by two staff members using the total mechanical lift from his/her recliner to his/her bed.

On 12/22/14 at 3:07 P.M. direct care staff Q revealed the resident was assisted with the full mechanical lift for all transfers.

On 12/23/14 at 9:04 A.M. licensed nursing staff J revealed the resident was a full mechanical lift and the care plan would reflect this.

On 12/23/14 at 10:23 A.M. administrative nursing staff D revealed administrative staff revises the care plans and he/she expects the care plan to be individualized and accurate including the way a resident transfers.

The policy and procedure for revising the care plan dated 9/1/14 provided by the facility revealed the care plan would be updated with new or modified interventions.

The facility failed to revise this cognitively impaired residents care plan to reflect the current care he/she was receiving while transferring.

- The annual Minimum Data Set (MDS) dated 11/5/14 for resident # 13 revealed he/she had

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memory problems and severely impaired cognitive skills for daily decision making. He/she displayed continuous signs and symptoms of delirium including inattention and psychomotor retardation. The resident was dependent on 2 or more staff for bed mobility, transfer, dressing, eating, and personal hygiene. He/she was not steady and was only able to stabilize with staff assistance from surface-to-surface transfers. He/she received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of an antianxiety medication (medication used for the treatment of anxiety; mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) during the 7 day look back period.

The 11/5/14 Care Area Assessment regarding falls revealed the resident was at risk for falls due to physical and mental condition.

The care plan with a review date of 11/6/14 revealed the resident was unable to bear weight and had poor safety awareness. Staff used a full body lift for all transfers.

The fall investigation for the 11/25/14 fall revealed staff had not secured one of the straps properly on the mechanical lift which led to the fall. Staff was educated regarding proper use of the lift.

The care plan failed to address this fall.

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F 280	Continued From page 10 Observation on 12/22/14 at 9:14 A.M. revealed the resident rested quietly in bed with his/her eyes closed. Interview on 12/22/14 at 4:27 P.M. with licensed staff H revealed the assistant director of nursing (ADON) and/or administrative nursing staff update the care plan. Staff H expected the care plan to be revised after each fall. Interview on 12/23/14 at 8:43 A.M. with direct care staff S revealed he/she expected the care plan to be updated after each fall to prevent future falls similar to that one and so staff were aware. Interview on 12/23/14 at 9:02 A.M. with licensed nursing staff I revealed the assistant of the ADON or the MDS coordinator updated the care plan. Staff I expected the care plan to be updated after each fall. Interview on 12/23/14 at 9:24 A.M. with administrative nursing staff E revealed he/she expected the care plan to be updated after each fall and acknowledged staff failed to update this resident's care plan after his/her most recent fall. The policy provided by the facility with a revision date of 7/30/2014 regarding the mechanical lift revealed staff were to fasten the straps to the front hook and fasten the bottom strap to the back hook on both sides. The facility failed to review and/or revise the care plan of this cognitively impaired resident after a fall to prevent future falls.	F 280		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to maintain hot water temperatures at or below 120 degrees Fahrenheit (F) for one of one days on survey site, and failed to properly transfer 1 (#13) resident with a Hoyer lift.

Findings included:

- On initial tour on 12/18/14 at 8:30 A.M. the North hallway shower room sink had a hot water temperature of 127.4 F and shower temperature of 124.5 F. A North hallway bathroom sink had a hot water temperature of 124.5 F. The door to the shower room and bathroom were unlocked and stood open. The Bistro (a kitchenette located by the dining room) had a hot water temperature of 127.5 F.

On 12/18/14 at 8:40 A.M. maintenance/housekeeping staff X was informed of the hot water temperatures and she/he acknowledged the hot water temperatures and would adjust the temperature of the hot water. She/he also stated hot water temperatures were

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checked monthly.

On 12/18/14 at 9:00 A.M. administrative nursing staff D stated the facility had three independent cognitively impaired mobile residents.

On 12/18/14 at 10:20 A.M. revealed the North hallway hot water temperatures were temped again and revealed a temperature of 126.5 F in the shower sink, 132.2 F in the shower, 125.6 in the North hallway bathroom and 125.2 F in the Bistro sink.

On 12/18/14 at 11:01 A.M. maintenance/housekeeping staff X stated she/he adjusted the hot water and would take time to cool the hot water.

Record review on 12/18/14 revealed a Water Temperature Reading log with documentation of monthly hot water checks. The month of December 2014 was blank.

On 12/18/14 from 9:00 A.M. to 5:30 P.M. revealed the following hot water temperatures on the North resident rooms were 127.0 degrees F, 124.6 degrees F, and 124.5 degrees F.

On 12/18/14 at 4:58 P.M. the North hallway hot water temperature in the shower room sink revealed a temperature of 125.4 F and 126.1 F in the Bistro sink.

Interview on 12/18/14 at 5:13 P.M. administrative staff A and administrative nursing staff D stated a plumber was notified of the hot water concerns and would come to the facility to inspect the hot water lines. They also stated the hot water would be turned of to the North hallway shower room,

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bathroom, and Bistro. All evening showers would be provided in the South shower room and the Bistro door locked.

The policy and procedure dated 11/2003 titled Monitoring of Hot Water Temperature revealed the maintenance department would test the hot water temperature weekly and hot water temperatures would be kept between 98 degrees to 115 degrees F.

The facility failed to monitor hot water temperature weekly and failed to maintain hot water between 98 degrees F and 115 degrees F per policy and procedure.

- The annual Minimum Data Set (MDS) dated 11/5/14 for resident # 13 revealed he/she had memory problems and severely impaired cognitive skills for daily decision making. He/she displayed continuous signs and symptoms of delirium including inattention and psychomotor retardation. The resident was dependent on 2 or more staff for bed mobility, transfer, dressing, eating, and personal hygiene. He/she was not steady and was only able to stabilize with staff assistance from surface-to-surface transfers. He/she received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of an antianxiety

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medication (medication used for the treatment of anxiety; mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) during the 7 day look back period.

The 11/5/14 Care Area Assessment regarding falls revealed the resident was at risk for falls due to physical and mental condition.

The care plan with a review date of 11/6/14 revealed the resident was unable to bear weight and had poor safety awareness. Staff used a full body lift for all transfers.

The 8/4/14, 11/3/14, and 11/25/14 fall risk assessment revealed a score of 15, indicating he/she was at risk for falls.

The nurse's note dated 11/25/14 at 7:45 A.M. revealed staff was assisting the resident with transfer using a mechanical lift when a strap came loose and the resident fell to the floor. While falling the resident hit his/her back on the lift and his/her head hit the floor.

The fall investigation for the 11/25/14 fall revealed staff had not secured one of the straps properly which led to the fall. Staff was educated regarding proper use of the lift.

Observation on 12/22/14 at 9:14 A.M. revealed the resident rested quietly in bed with his/her eyes closed.

Interview on 12/22/14 at 4:27 P.M. with licensed staff H revealed the resident was considered a fall risk due to potential to roll out of bed. Staff H reported the fall that occurred on 11/25/14 was due to a strap of the lift slipping off. He/she

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F 323	Continued From page 15 reported all nursing aides were reeducated on the proper use of the lift for transfers. Interview on 12/23/14 at 9:02 A.M. with licensed nursing staff I revealed upon hire staff were educated on the proper use of the lift for transfers and was reeducated at the facility's annual skills fair. Interview on 12/23/14 at 9:57 A.M. with administrative nursing staff D revealed staff were educated upon hire regarding proper use of the lift. He/she expected staff to use proper technique when transferring residents using a lift. The policy provided by the facility with a revision date of 7/30/2014 regarding the mechanical lift revealed staff were to fasten the straps to the front hook and fasten the bottom strap to the back hook on both sides. The facility failed to ensure the safety of this cognitively impaired resident by using proper technique with transfers using a lift.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

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resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to develop specific target behaviors for psychotropic medication use for 4 (#2, #13, #33, #34) of 5 residents reviewed for medications.

Findings included:

- The annual Minimum Data Set (MDS) dated 10/16/14 for resident #2 revealed a Brief Interview for Mental Status score (BIMS) of 5, indicating severe cognitive impairment. He/she was totally dependent on 2 or more staff for bed mobility, transfer, dressing, and toilet use. The resident received 7 injections of insulin, 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (medication used for the treatment of

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depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of a diuretic (medication to promote the formation and excretion of urine) during the 7 day look back period.

The 10/20/14 Care Area Assessment regarding psychotropic medication use revealed the resident was started on these medications in 2010 due to seeing Jesus in his/her window, talking nonstop, and agitation. He/she had the diagnoses of major depression with psychosis, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The Care plan with a revision date of 10/27/14 revealed staff gave medications as ordered and monitored for side effects and effectiveness.

The physician's order sheet signed 12/2/14 revealed the following medications and start dates: 4/20/10 Remeron (antidepressant medication), 6/11/10 Seroquel XR (antipsychotic medication).

The telephone order dated 9/26/14 revealed Lexapro (antidepressant medication) was discontinued.

The quarterly evaluation of psychotropic medication use dated 10/14/14 revealed the behaviors that warranted the use of these medications included seeing people, kids, and black cats in his/her room under his/her bed.

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The behavior monitoring sheets for October 2014, November 2014, and December 2014 showed the resident received Lexapro, Remeron, and Seroquel. The form was standardized and lacked specific target behaviors for staff to monitor for this resident. Also, this resident had not received Lexapro since September 2014.

Observation on 12/22/14 revealed the resident rested quietly in a recliner in his/her room with his/her eyes closed.

Interview on 12/22/14 @ 4:27 P.M. with licensed nursing staff H revealed the behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the forms lacked specific target behaviors. He/she also acknowledged it would be difficult to determine effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them. Staff H reported the resident was no longer receiving Lexapro.

Interview on 12/23/14 at 9:02 A.M. with licensed nursing staff I revealed that staff document any behaviors seen on the forms and they lacked specific target behaviors for each resident. Staff I acknowledged it would be beneficial for staff to know what target behaviors to watch for to determine effectiveness of medications.

Interview on 12/23/14 at 9:24 A.M. with administrative nursing staff E revealed he/she acknowledged the behavior monitoring forms lacked specific target behaviors for the resident

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and that this resident no longer received Lexapro.

Interview on 12/23/14 at 9:57 A.M. with administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to be individualized for each resident and he/she acknowledged this resident no longer received Lexapro.

The policy provided by the facility with an effective date of 11/2003 regarding behavior monitoring revealed the nurse was responsible for developing the behavior monitoring sheet and identify specific displayed (target) behaviors to be assessed and individual interventions by writing them in the spaces provided.

The facility failed to individualize and update the behavior monitoring sheet for this severely cognitively impaired resident receiving psychotropic medications.

- The annual Minimum Data Set (MDS) dated 11/5/14 for resident # 13 revealed he/she had memory problems and severely impaired cognitive skills for daily decision making. He/she displayed continuous signs and symptoms of delirium including inattention and psychomotor retardation. The resident was dependent on 2 or more staff for bed mobility, transfer, dressing, eating, and personal hygiene. He/she received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7

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doses of an antianxiety medication (medication used for the treatment of anxiety; mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) during the 7 day look back period.

The 11/6/14 Care Area Assessment for psychotropic medication use revealed he/she received medication due to yelling out at night, had anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and had a history of hallucinations (sensing things while awake that appear to be real, but the mind created).

The care plan with a reviewed date of 11/6/14 revealed the resident was resistive to cares and cried out.

The physician's order sheet signed 12/2/14 revealed the following medications and start dates: 5/3/11 Trazadone (antidepressant medication), 11/13/13 Ativan cream (antianxiety medication), 11/25/13 Seroquel (antipsychotic medication).

The quarterly evaluation of psychotropic medication use dated 11/4/14 revealed the behaviors that warranted the use of these medications included yelling out.

The behavior monitoring sheets for October 2014, November 2014, and December 2014 showed the resident received Seroquel, Trazadone, and Ativan cream. The form was standardized and lacked specific target behaviors for staff to monitor for this resident.

Observation on 12/22/14 at 2:10 P.M. revealed

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the resident rested quietly in bed with his/her eyes closed.

Interview on 12/22/14 @ 4:27 P.M. with licensed nursing staff H revealed the behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the forms lacked specific target behaviors. He/she also acknowledged it would be difficult to determine effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them. Staff H reported this resident frequently yelled out.

Interview on 12/23/14 at 8:43 A.M. with direct care staff S revealed the resident frequently yelled out.

Interview on 12/23/14 at 9:02 A.M. with licensed nursing staff I revealed that staff document any behaviors seen on the forms and they lacked specific target behaviors for each resident. Staff I acknowledged it would be beneficial for staff to know what target behaviors to watch for to determine effectiveness of medications. Staff I reported this resident frequently yelled out, almost daily.

Interview on 12/23/14 at 9:24 A.M. with administrative nursing staff E revealed he/she acknowledged the behavior monitoring forms lacked specific target behaviors for the resident.

Interview on 12/23/14 at 9:57 A.M. with administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to

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be individualized for each resident.

The policy provided by the facility with an effective date of 11/2003 regarding behavior monitoring revealed the nurse was responsible for developing the behavior monitoring sheet and identify specific displayed (target) behaviors to be assessed and individual interventions by writing them in the spaces provided.

The facility failed to individualize the behavior monitoring sheet for this severely cognitively impaired resident receiving psychotropic medications.

- The Physician's Order Sheet (POS) signed on 12/2/14 for resident # 34 revealed diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia (progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and agitation.

The Significant change Minimum Data Set (MDS) dated 12/3/14 revealed the resident had severe cognitive impairment and received antipsychotics, antidepressants, and antianxiety medication.

The Communication Care Area Assessment (CAA) dated 12/8/14 revealed the resident was very anxious and cries out frequently. The resident had spent time in a geriatric psychotic unit and his/her behaviors were not improved.

The Psychotropic CAA revealed he/she was followed by a psychiatrist for his/her medication

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regimen.

The care plan updated on 12/15/14 revealed the resident had cognitive loss, yelled out and had anxiety.

Review of the POS signed on 12/2/14 revealed the resident received the following medications:
Seroquel (an antipsychotic medication)12.5 milligrams (mg) by mouth (PO) five times daily ordered on 11/26/14 and lacked a diagnosis for this medication
Diazepam (an antianxiety medication) 2 mg PO three times daily for anxiety/agitation ordered on 11/26/14
Depakote (an antiseizure medication used for mood stabilization) 125 mg PO four times daily for mood stabilizer ordered on 11/26/14
Trazadone (an antidepressant medication) 50 mg PO daily for depression ordered on 8/14/14
Fluvoxamine Maleate (an antidepressant medication) 125 mg PO daily for obsessions ordered on 11/26/14.
The following medications were ordered as needed (PRN) in which the resident received during the month of December:
Zyprexa (an antipsychotic medication)2.5 mg PO every 4 hours prn for anxiety ordered on 12/21/14
Lorazepam (an antianxiety medication) 0.5 mg PO every 4 hours needed for anxiety ordered on 12/22/14

Review of the October behavior monitoring flow sheets revealed the resident received Lexapro, Trazadone, Clonazepam, and Seroquel. The form was standardized and lacked specific target behaviors for staff to monitor for this resident.

Review of the November behavior monitoring flow

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sheets revealed the resident received Lexapro, Trazadone, Clonazepam, and Seroquel. The form was standardized and lacked specific target behaviors for staff to monitor for this resident.

Review of the December behavior monitoring flow sheets revealed the resident received Diazepam, Trazadone, Fluvoxomine, and Seroquel. The form was standardized and lacked specific target behaviors for staff to monitor for this resident. The resident also received Lorazepam, Depakote, Zyprexa which were not listed on the behavior monitoring flow sheet.

Observation on 12/22/14 at 2:09 P.M. the resident was yelling help, a direct care staff went into room and held the residents hand, which calmed him/her down.

Interview on 12/22/14 at 4:27 P.M. with licensed nursing staff H revealed behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the form lack specific targeted behaviors. He/she also acknowledged it would be difficult to determine the effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them.

Interview on 12/23/14 at 10:23 A.M. administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to be individualized for each resident and to be accurate with what psychotropic medications the resident is receiving.

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The policy provided by the facility with an effective date of 11/2003 regarding behavior monitoring revealed the nurse was responsible for developing the behavior monitoring sheet and identify specific displayed (target) behaviors to be assessed and individual interventions by writing them in the spaces provided.

The facility failed to individualize and update the behavior monitoring sheets for this severely cognitively impaired resident receiving psychotropic medications.

- The Physicians Order Sheet (POS) signed on 12/4/14 for resident #33 revealed the diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and insomnia (inability to sleep).

The Significant change Minimum Data Set (MDS) dated 7/18/14 revealed the resident had severe cognitive impairment and received antipsychotics, antidepressants, antianxiety and hypnotic medication.

The Mood Care Area Assessment (CAA) dated 7/18/14 revealed the resident was restless and would pace into other resident rooms.

The Psychotropic CAA revealed he/she received Celexa, Restoril, Ativan, Seroquel and Trazadone

The care plan updated on 12/22/14 revealed the resident displayed restlessness, and behaviors such as striking out had decreased.

Review of the December POS signed 12/4/14 revealed the resident received the following

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medications:
Celexa (an antidepressant medication) 20 milligrams (mg) by mouth (PO) for depression ordered on 6/25/14
Seroquel (an antipsychotic medication) 50 mg PO daily for acute psychosis ordered on 6/25/14
Seroquel 100 mg PO at bedtime (HS) for acute psychosis ordered on 6/25/14
Restoril (a hypnotic medication)15 mg PO as needed (PRN) for insomnia ordered on 8/27/14
Ativan (an antianxiety medication) 0.5 mg PO every two hours PRN for anxiety and lacked an order date.

Review of the October, November and December behavior monitoring flow sheets revealed the resident had orders for Celexa, Seroquel, Ativan, and Restoril The form was standardized and lacked specific target behaviors for staff to monitor for this resident.

Observation on 12/22/14 at 9:43 A.M. the resident rested quietly in bed.

Interview on 12/22/14 at 4:27 P.M. with licensed nursing staff H revealed behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the form lack specific targeted behaviors. He/she also acknowledged it would be difficult to determine the effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them.

Interview on 12/23/14 at 10:23 A.M. administrative nursing staff D revealed he/she

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F 329	Continued From page 27 would expect the behavior monitoring sheets to be individualized for each resident. The policy provided by the facility with an effective date of 11/2003 regarding behavior monitoring revealed the nurse was responsible for developing the behavior monitoring sheet and identify specific displayed (target) behaviors to be assessed and individual interventions by writing them in the spaces provided. The facility failed to individualize and update the behavior monitoring sheets for this severely cognitively impaired resident receiving psychotropic medications.	F 329		
F 354 SS=D	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 32 residents. Based on record review and interview the facility failed to have scheduled Registered Nurse (RN)	F 354		

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F 354	Continued From page 28 coverage for 4 of 4 weekends during December 2014. Findings included: - Review of the facility schedule for December 2014 revealed no RN coverage was scheduled for December 6th, 7th, 13th, 14th, 20th, 21st, 27th and 28th. Interview on 12/22/14 at 3:42 P.M. administrative staff A revealed he/she was able to count RN coverage on the acute care side since it was under the same licensure. The policy and procedure dated 12/21/14 for Nurse staffing provided by the facility revealed Community Hospital and Community Hospital Long Term care Unit (LTCU) share RN's and RN's were immediately available for LTCU help, to meet the requirements of 8 consecutive hours, 7 days a week of RN coverage. The facility failed to provide RN coverage for 8 consecutive hours, 7 days a week.	F 354		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
The facility had 1 kitchen. Based on observation, interview, and record review the facility failed to distribute and serve food under sanitary conditions on 1 of 3 days on site.

Findings included:

- Observation on 12/22/14 at 11:52 A.M. dietary staff DD had gloved hands and touched serving utensils, dietary card/paper, hamburger bun packaging and then with same gloved hand directly touched the top hamburger bun then continued to make the plate for a resident.

Observation on 12/22/14 at 12:08 P.M. dietary staff EE had gloved hands and touched mustard packets, ketchup packets, his/her own apron, sandwich bags containing pieces of bread, then received a prepared plate from dietary staff DD containing a hamburger with a bun. After taking the plate staff EE picked up the top hamburger and set it on another portion of the plate, without changing gloves.

Observation on 12/22/14 at 12:28 P.M. dietary staff DD placed tongs directly on the unclean hamburger bun packaging. He/she then picked them back up and used them to pick up a hamburger bun and set it on a plate to be served to a resident.

Interview on 12/22/14 at 11:53 A.M. with dietary staff DD revealed he/she knew directly touching the hamburger bun with an unclean glove was not proper technique. He/she acknowledged clean utensils or new gloves should be used to handle

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F 371	Continued From page 30 foods. Interview on 12/22/14 at 12:09 P.M. with dietary staff EE revealed he/she acknowledged touching food with unclean gloves was not proper technique. Interview on 12/22/14 at 12:29 P.M. with dietary staff DD revealed he/she was aware the hamburger bun packaging was not a clean surface and should not rest serving utensils on it. The policy provided by the facility with a revision date of 5/3/12 regarding infection control during food preparation revealed staff ensured all foods were prepared and served in the most sanitary manner to maintain quality, appearance and nutritive value. Foods products should be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implement so as to avoid manual contact of prepared foods. Staff was to handle utensils, cups, glasses, dishes in such a way as to avoid touching surfaces with food or drink will come in contact with. The facility failed to handle and serve food under sanitary conditions.	F 371		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview the consultant pharmacist failed to recognize and notify the facility of their failure to develop specific target behaviors for psychotropic medication use for 4 (#2, #13, #33, #34) of 5 residents reviewed for medications. The facility failed to follow pharmacy recommendations for 1 (#34) resident regarding the need for a diagnosis for a psychotropic medication.

Findings included:

- The annual Minimum Data Set (MDS) dated 10/16/14 for resident #2 revealed a Brief Interview for Mental Status score (BIMS) of 5, indicating severe cognitive impairment. He/she was totally dependent on 2 or more staff for bed mobility, transfer, dressing, and toilet use. The resident received 7 injections of insulin, 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of a diuretic (medication to promote the formation and excretion of urine) during the 7 day look back period.

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The 10/20/14 Care Area Assessment regarding psychotropic medication use revealed the resident was started on these medications in 2010 due to seeing Jesus in his/her window, talking nonstop, and agitation. He/she had the diagnoses of major depression with psychosis, dementia (progressive mental disorder characterized by failing memory, confusion), and Parkinson's (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The Care plan with a revision date of 10/27/14 revealed staff gave medications as ordered and monitored for side effects and effectiveness.

The physician's order sheet signed 12/2/14 revealed the following medications and start dates: 4/20/10 Remeron (antidepressant medication), 6/11/10 Seroquel XR (antipsychotic medication).

The telephone order dated 9/26/14 revealed Lexapro (antidepressant medication) was discontinued.

The quarterly evaluation of psychotropic medication use dated 10/14/14 revealed the behaviors that warranted the use of these medications included seeing people, kids, and black cats in his/her room under his/her bed.

The behavior monitoring sheets for October 2014, November 2014, and December 2014 showed the resident received Lexapro, Remeron, and Seroquel. The form was standardized and lacked specific target behaviors for staff to

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monitor for this resident. Also, this resident had not received Lexapro since September 2014.

The Monthly Regimen Review revealed the consultant pharmacist reviewed the resident's medications and record on the following dates: 12/30/13, 1/0/14, 2/14/14, 3/14/14, 4/11/14, 5/23/14, 6/13/14, 7/11/14, 8/15/14, 9/12/14, 10/14/14, 11/21/14, and 12/8/14. Review of the pharmacists notes failed to show he/she recognized and notified the facility of the lack of specific target behaviors and continued listing of Lexapro on the behavior monitoring sheets.

Observation on 12/22/14 revealed the resident rested quietly in a recliner in his/her room with his/her eyes closed.

Interview on 12/22/14 @ 4:27 P.M. with licensed nursing staff H revealed the behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the forms lacked specific target behaviors. He/she also acknowledged it would be difficult to determine effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them. Staff H reported the resident was no longer receiving Lexapro.

Interview on 12/23/14 at 9:02 A.M. with licensed nursing staff I revealed that staff document any behaviors seen on the forms and they lacked specific target behaviors for each resident. Staff I acknowledged it would be beneficial for staff to know what target behaviors to watch for to determine effectiveness of medications.

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Interview on 12/23/14 at 9:24 A.M. with administrative nursing staff E revealed he/she acknowledged the behavior monitoring forms lacked specific target behaviors for the resident and that this resident no longer received Lexapro.

Interview on 12/23/14 at 9:57 A.M. with administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to be individualized for each resident and he/she acknowledged this resident no longer received Lexapro.

Interview on 12/23/14 at 10:52 A.M. with consultant pharmacist JJ revealed he/she did review the behavior monitoring sheets but did not feel target behaviors were beneficial to evaluating the effectiveness of psychotropic medications. Consultant staff JJ reported he/she did not always ensure the medications listed on the behavior monitoring sheets were accurate.

The policy provided by the facility with an effective date of 11/2003 regarding behavior monitoring revealed the nurse was responsible for developing the behavior monitoring sheet and identify specific displayed (target) behaviors to be assessed and individual interventions by writing them in the spaces provided.

The policy provided by the facility dated 12/23/14 regarding drug regimen review revealed the consultant pharmacist performed drug regimen reviews on each resident at least monthly.

The consultant pharmacist failed to recognize and notify the facility of their failure to individualize and update the behavior monitoring sheet for this

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severely cognitively impaired resident receiving psychotropic medications.

- The annual Minimum Data Set (MDS) dated 11/5/14 for resident # 13 revealed he/she had memory problems and severely impaired cognitive skills for daily decision making. He/she displayed continuous signs and symptoms of delirium including inattention and psychomotor retardation. The resident was dependent on 2 or more staff for bed mobility, transfer, dressing, eating, and personal hygiene. He/she received 7 doses of an antipsychotic medication (medication used for the treatment of psychosis; any major mental disorder characterized by a gross impairment in reality testing), 7 doses of an antidepressant medication (medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and 7 doses of an antianxiety medication (medication used for the treatment of anxiety; mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) during the 7 day look back period.

The 11/6/14 Care Area Assessment for psychotropic medication use revealed he/she received medication due to yelling out at night, had anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and had a history of hallucinations (sensing things while awake that appear to be real, but the mind created).

The care plan with a reviewed date of 11/6/14 revealed the resident was resistive to cares and cried out.

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The physician's order sheet signed 12/2/14 revealed the following medications and start dates: 5/3/11 Trazadone (antidepressant medication), 11/13/13 Ativan cream (antianxiety medication), 11/25/13 Seroquel (antipsychotic medication).

The quarterly evaluation of psychotropic medication use dated 11/4/14 revealed the behaviors that warranted the use of these medications included yelling out.

The behavior monitoring sheets for October 2014, November 2014, and December 2014 showed the resident received Seroquel, Trazadone, and Ativan cream. The form was standardized and lacked specific target behaviors for staff to monitor for this resident.

The Monthly Regimen Review revealed the consultant pharmacist reviewed the resident's medications and record on the following dates: 12/30/13, 1/0/14, 2/14/14, 3/14/14, 4/11/14, 5/23/14, 6/13/14, 7/11/14, 8/15/14, 9/12/14, 10/14/14, 11/21/14, and 12/8/14. Review of the pharmacists notes failed to show he/she recognized and notified the facility of the lack of specific target behaviors.

Observation on 12/22/14 at 2:10 P.M. revealed the resident rested quietly in bed with his/her eyes closed.

Interview on 12/22/14 @ 4:27 P.M. with licensed nursing staff H revealed the behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H

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acknowledged the forms lacked specific target behaviors. He/she also acknowledged it would be difficult to determine effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them. Staff H reported this resident frequently yelled out.

Interview on 12/23/14 at 8:43 A.M. with direct care staff S revealed the resident frequently yelled out.

Interview on 12/23/14 at 9:02 A.M. with licensed nursing staff I revealed that staff document any behaviors seen on the forms and they lacked specific target behaviors for each resident. Staff I acknowledged it would be beneficial for staff to know what target behaviors to watch for to determine effectiveness of medications. Staff I reported this resident frequently yelled out, almost daily.

Interview on 12/23/14 at 9:24 A.M. with administrative nursing staff E revealed he/she acknowledged the behavior monitoring forms lacked specific target behaviors for the resident.

Interview on 12/23/14 at 9:57 A.M. with administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to be individualized for each resident.

Interview on 12/23/14 at 10:52 A.M. with consultant pharmacist JJ revealed he/she did review the behavior monitoring sheets but did not feel target behaviors were beneficial to evaluating the effectiveness of psychotropic medications.

The policy provided by the facility with an effective

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date of 11/2003 regarding behavior monitoring revealed the nurse was responsible for developing the behavior monitoring sheet and identify specific displayed (target) behaviors to be assessed and individual interventions by writing them in the spaces provided.

The policy provided by the facility dated 12/23/14 regarding drug regimen review revealed the consultant pharmacist performed drug regimen reviews on each resident at least monthly.

The consultant pharmacist failed to recognize and notify the facility of their failure to individualize the behavior monitoring sheet for this severely cognitively impaired resident receiving psychotropic medications.

- The Physician's Order Sheet (POS) signed on 12/2/14 for resident # 34 revealed diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), dementia (progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and agitation.

The Significant change Minimum Data Set (MDS) dated 12/3/14 revealed the resident had severe cognitive impairment and received antipsychotics, antidepressants, and antianxiety medication.

The Communication Care Area Assessment (CAA) dated 12/8/14 revealed the resident was very anxious and cries out frequently. The resident had spent time in a geriatric psychotic

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unit and his/her behaviors were not improved.

The Psychotropic CAA revealed he/she was followed by a psychiatrist for his/her medication regimen.

The care plan updated on 12/15/14 revealed the resident had cognitive loss, yelled out and had anxiety.

Review of the POS signed on 12/2/14 revealed the resident received the following medications:
Seroquel (an antipsychotic medication)12.5 milligrams (mg) by mouth (PO) five times daily ordered on 11/26/14 and lacked a diagnosis for this medication
Diazepam (an antianxiety medication) 2 mg PO three times daily for anxiety/agitation ordered on 11/26/14
Depakote (an antiseizure medication used for mood stabilization) 125 mg PO four times daily for mood stabilizer ordered on 11/26/14
Trazadone (an antidepressant medication) 50 mg PO daily for depression ordered on 8/14/14
Fluvoxamine Maleate (an antidepressant medication) 125 mg PO daily for obsessions ordered on 11/26/14.
The following medications were ordered as needed (PRN) in which the resident received during the month of December:
Zyprexa (an antipsychotic medication)2.5 mg PO every 4 hours prn for anxiety ordered on 12/21/14
Lorazepam (an antianxiety medication) 0.5 mg PO every 4 hours needed for anxiety ordered on 12/22/14

Review of the October behavior monitoring flow sheets revealed the resident received Lexapro, Trazadone, Clonazepam, and Seroquel. The form

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was standardized and lacked specific target behaviors for staff to monitor for this resident.

Review of the November behavior monitoring flow sheets revealed the resident received Lexapro, Trazadone, Clonazepam, and Seroquel. The form was standardized and lacked specific target behaviors for staff to monitor for this resident.

Review of the December behavior monitoring flow sheets revealed the resident received Diazepam, Trazadone, Fluvoxomine, and Seroquel. The form was standardized and lacked specific target behaviors for staff to monitor for this resident. The resident also received Lorazepam, Depakote, Zyprexa which were not listed on the behavior monitoring flow sheet.

The Monthly Regimen Review revealed the consultant pharmacist reviewed the resident's medications and record on the following dates: 6/13/14, 7/11/14, 8/15/14, 9/12/14, 10/14/14, 11/21/14, and 12/8/14. Review of the pharmacist ' s notes failed to show he/she recognized and notify the facility the lack of specific target behaviors. His/her notes did reveal on 7/11/14 he/she recommended to the facility to add a diagnosis for the use of Seroquel.

Review of the Physician communication note signed on 7/21/14 revealed the resident recieved Seroquel with a diagnosis of major depression, treatment refractory (mood disorder).

Observation on 12/22/14 at 2:09 P.M. the resident was yelling help, a direct care staff went into room and held the residents hand, which calmed him/her down.

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Interview on 12/22/14 at 4:27 P.M. with licensed nursing staff H revealed behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the form lack specific targeted behaviors. He/she also acknowledged it would be difficult to determine the effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them.

Interview on 12/23/14 at 10:23 A.M. administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to be individualized for each resident and to be accurate with what psychotropic medications the resident is receiving.

The policy provided by the facility dated 12/23/14 regarding drug regimen review revealed the consultant pharmacist performed drug regimen reviews on each resident at least monthly.

The facility failed to follow pharmacy reccommendations for adding a diagnosis for Seroquel and the pharmacist failed to identify that the facility lacked to individualize and update the behavior monitoring sheets for this severely cognitively impaired resident receiving psychotropic medications.

- The Physicians Order Sheet (POS) signed on 12/4/14 for resident #33 revealed the diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and insomnia (inability to sleep).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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The Significant change Minimum Data Set (MDS) dated 7/18/14 revealed the resident had severe cognitive impairment and received antipsychotics, antidepressants, antianxiety and hypnotic medication.

The Mood Care Area Assessment (CAA) dated 7/18/14 revealed the resident was restless and would pace into other resident rooms.

The Psychotropic CAA revealed he/she received Celexa, Restoril, Ativan, Seroquel and Trazadone

The care plan updated on 12/22/14 revealed the resident displayed restlessness, and behaviors such as striking out had decreased.

Review of the December POS signed 12/4/14 revealed the resident received the following medications:
Celexa (an antidepressant medication) 20 milligrams (mg) by mouth (PO) for depression ordered on 6/25/14
Seroquel (an antipsychotic medication) 50 mg PO daily for acute psychosis ordered on 6/25/14
Seroquel 100 mg PO at bedtime (HS) for acute psychosis ordered on 6/25/14
Restoril (a hypnotic medication)15 mg PO as needed (PRN) for insomnia ordered on 8/27/14
Ativan (an antianxiety medication) 0.5 mg PO every two hours PRN for anxiety and lacked an order date.

Review of the October, November and December behavior monitoring flow sheets revealed the resident had orders for Celexa, Seroquel, Ativan, and Restoril The form was standardized and lacked specific target behaviors for staff to

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	17E242	A. BUILDING _____ B. WING _____	12/24/2014

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monitor for this resident.

The Monthly Regimen Review revealed the consultant pharmacist reviewed the resident's medications and record on the following dates: 5/23/14, 6/13/14, 7/11/14, 8/15/14, 9/12/14, 10/14/14, 11/21/14, and 12/8/14. Review of the pharmacist ' s notes failed to show he/she recognized and notify the facility the lack of specific target behaviors.

Observation on 12/22/14 at 9:43 A.M. the resident rested quietly in bed.

Interview on 12/22/14 at 4:27 P.M. with licensed nursing staff H revealed behavior monitoring forms were standardized and put into place for all resident's receiving psychotropic medications. Staff H reported the admitting nurse developed the behavior monitoring forms. Staff H acknowledged the form lack specific targeted behaviors. He/she also acknowledged it would be difficult to determine the effectiveness of the medications since there were multiple classes of medications listed with no specific target behaviors associated with them.

Interview on 12/23/14 at 10:23 A.M. administrative nursing staff D revealed he/she would expect the behavior monitoring sheets to be individualized for each resident.

The policy provided by the facility dated 12/23/14 regarding drug regimen review revealed the consultant pharmacist performed drug regimen reviews on each resident at least monthly.

The pharmacist failed to identify that the facility lacked to individualize and update the behavior

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F 428	Continued From page 44 monitoring sheets for this severely cognitively impaired resident receiving psychotropic medications.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		

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transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 32 residents. Based on observation and staff interview the facility failed to utilize precautions to minimize the transmission of infection during one of one room cleaning observed.

Findings included:

- Observation on 12/22/14 between 8:29 A.M. and 8:37 A.M. housekeeping staff Z wore the same gloves throughout room clean.

Observation on 12/22/14 at 8:32 A.M. housekeeping staff Z cleaned the toilet riser with bleach. The toilet riser was wiped with damp cloth and was dry at 8:33 A.M.

Observation on 12/22/14 at 9:10 A.M. housekeeping staff Y mopped the floor with floor cleaner #2.

The chemicals used for cleaning of the room were Suprox 33 (not disinfectant), Window cleaner 2 (not disinfectant), floor cleaner #2 (not a disinfectant) bleach (disinfectant- housekeeping staff X reported a dry time of 10 minutes), Re-Juv-Nal (disinfectant with a dry time of 10 minutes).

Interview on 12/22/14 at approximately 8:55 A.M. housekeeping staff Y revealed housekeeping staff does not disinfect or sanitize resident rooms

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on a daily basis, that the only time that happens is if someone was sick, leaves the facility or moves rooms within the facility. He/she stated housekeeping staff wipe the door knobs down once a week. Housekeeping staff Y revealed the floor cleaner #10 is not a disinfectant or sanitizer and does not have a dry time, the only chemical the facility used that disinfects was the cavi wipes, bleach and Re-Juv-Nal #16, which have a 10 minute dry time and staff must completely saturate the room in order for it to stay wet for 10 minutes.

Interview on 12/22/14 at 11:06 A.M. with housekeeping staff X and housekeeping staff AA revealed the facility just switched over to a different brand of chemicals and the Re- Juv-Nal #16 should be used on the toilet, and door knobs which should be done with every room clean. The chemical must stay wet for 10 minutes, and staff were expected to saturate the rag completely so it stays wet for 10 minutes. Staff is to change gloves after cleaning the toilet.
Housekeeping staff X revealed the bleach has a dry time of 10 minutes, if staff were using it.

The policy and procedure for infection control dated 2/1/2000 provided by the facility revealed housekeeping in the facility should be performed on a routine and consistent basis to provide a safe and sanitary

The facility failed to utilize precautions to minimize the transmission of infection.